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CONSUMER TASK FORCE

JUNE 26, 2007

Consumer Task Force Executive Meeting

June 4, 2007

ATTENDEES: Laura Hall, RoAnne Chaney, Paul Palmer, Jack Vint, Verna Spayth, Yuself Seegars, Orystine Gully, Sara Harrison, Sue McBrien, Jacqui Day, Colleen Widder (Phone).

Last Task Force Meeting: Laura asked for comments concerning that last Task Force Meeting. Responses included that the meeting was still somewhat focused on reporting vs. discussion of how CTF can contribute to the grant projects. The Executive Committee will continue to work on structuring the meetings to allow for more discussion among members.

Agenda

a. Person Centered Planning Guidelines Implementation - Rob - Discussion about providing 1 hour for Rob to present and members to provide feedback. Group suggests that the meeting potentially be extended by 30 min, as there may be quite a bit of discussion on this topic. Laura will check with Jackie T. on this

b. Project Updates - Format - There is concern of time. Suggestions include limiting time for reports, asking for reports only on project barriers, CTF role, current issues, accomplishments, etc. Most important is that the CTF get information about projects that provide information about how the CTF can be involved, or support the project or issue.

c. Consumer Introductions - Committee agrees the importance of meeting each of the members. With the Task Force gaining new membership it is suggested that each member is important and has much to provide the CTF. As a means of meeting members, it is suggested that members give biographies of themselves. Because of the time frame of the general meeting, it is suggested only 1 or 2 per meeting begin. Yuself and Laura will start at the next meeting.

Informational Sessions

Comment: People are looking forward to these sessions.

What will they include? - It was noted that topics such as the grant projects, waivers, State Plan, etc. all need to be included at some point in the informational sessions. However, it was suggested that beginning with the history of LTC reform and how it led up to the creation of the CTF would be a good place to begin. RoAnne and Verna have a great deal of knowledge on this topic and can present the information at the first session. It was decided that the first informational session will be held after the Task Force meeting from 1:00-2:00pm. The Executive Committee Meeting will be held after the informational session for members from 2:00-3:00pm

Consumer Task Force Binder - Jackie's Outline

-Laura added questions to the copy handed out. Copy of handout to Jackie for review
-Item under Medicaid is missing LTC as a topic
-Waiver description it is suggested that there be a 1-2 sentence description for each of the topics. Longer descriptions can be confusing
-It is mentioned that TBI could be the New Waiver topic on the outline
-Comment that Real Choice, as seen under the list of Grants, is a terminated grant
-Missing under grants are MFP, MFP/DRA/MIG, and ADRC
-More history in the outline would be helpful for members

Other

Reminder to bring lunch to the next CTF meeting, as the informational session and Executive Committee Meeting will follow. General CTF meeting will be 10-12:30

Close of meeting approved by members

OFFICE OF LONG-TERM CARE SUPPORTS & SERVICES
Update for the Long-Term Care Supports and Services Advisory Commission

June 25, 2007

1. LTC Connections (LTCC) Projects
    a. The contracts to the Area Agencies on Aging have been cancelled. Most of the new contracts to the LTC Connections have been sent to the agencies for signatures. The Detroit LTC Connections should be ready soon. There will be a 30-day overlap of functions and personnel for transition to the new entity.
    b. The Evaluators and the Quality Management Subcommittee developed a draft of the Information and Assistance consumer experience survey and protocol. It is being circulated for feedback, and will be pilot tested over the next 5 weeks or so.
    c. A document that identifies each of the LTC Connections governing and consumer advisory boards is being prepared. Responses are due from the LTC Connections June 20th.
    d. A contract has been signed with the Michigan Public Health Institute to provide the independent evaluation of the demonstration sites.

2. System Transformation Grant Project
    a. On June 15th, the revised strategic plan was submitted to CMS. There were not any substantive changes from our original submission.
    b. A workgroup will be assembled to refine the evaluation plan. A draft evaluation plan was submitted as part of the strategic plan. We now have until August 3rd to expand this with additional detail. The workgroup will draw members

from the three workgroups that developed the strategic plan.

3. Office Development
   a. The Office submitted a request to fill several positions, including the Systems Transformation and Deficit Reduction/Money Follows the Person project managers, to Governor's Office.
   b. The planned move to Capitol View Building is still on hold.

4. Long-Term Care Insurance Partnership program
   a. reported previously, Michigan was awarded a $50,000 seed grant from the RWJ Center for Health Care Strategies to implement a Partnership program. The seed grant will be used primarily to support consumer and producer education.

   b. A grant-required planning committee has been convened. It is comprised of state stakeholders (DCH MSA Policy, OLTCSS, OSA, OFIS (Office of Financial and Insurance Services and DHS), consumers, advocates, and insurance industry representatives.

   c. The OLTCSS held a meeting to orient internal (state) stakeholders to the Partnership and identify issues that might need to be addressed during project implementation. A meeting of the full planning committee was held on June 22. It serves as the official kick-off of activities related to development of a Partnership in Michigan.

   d. Several members of the planning committee will be attending a grant-related kick-off meeting in Arlington in late July. The long-range plan is to have partnership

products available for sale in Michigan markets by July 2008.

5. MIChoice Waiver Renewal Stakeholder Forums
   a. The renewal waiver package is currently in the process of obtaining internal DCH approval. It should be submitted to CMS by Jund 30th.
   b. The stakeholder workgroup met June 15th to discuss the waiver submission plan and future amendments to the waiver.
   c. The Specialized Residential Licensed Setting subcommittee will continue to meet to examine the implications of placing into the MIChoice waiver a covered service option that will pay for special licensed residential settings (Adult Foster Care and Homes for the Aged).

6. Prepaid LTC Health Plan pilot project
   a. The design of a feasibility study has been presented to the contractor, Health Management Associates.
   b. The concept paper has been finalized and submitted to CMS for comments.

7. Deficit Reduction Act - Money Follows the Person grant
   a. A stakeholder group will be formed to provide input on the Operational Protocol. This document is due to CMS in August.

8. Self-Determination in Long-Term Care
   a. The Department co-sponsored the 10th annual Self-Determination Conference, with the Michigan Association of Community Mental Health Boards last week. There were over 400 attendees. Preliminary results of the evaluations indicate another successful year for this conference.

b. Staff has begun training the 17 remaining MI Choice waiver agents, that were not part of the pioneer efforts under Cash and Counseling, in Person-Centered Planning in order to expand Self-Determination statewide. This is the first of three phases of training for this group.
c. The Person-Centered Planning Practice and Guidelines draft has been shared with the Commission via a previous mailing. Comments should be sent to Gloria Lanum at lanumg@michigan.gov.

9. Other
b. The budget continues to be a very large part of the Office's energy. The affect on the grant projects is unknown at this time. The FY08 budget is on hold until the revenue issue is resolved.

CONSUMER TASK FORCE

UPDATE OF PROJECTS

JUNE 2007

Medicaid Infrastructure Grant (MIG)
June 2007

There are presently 983 Freedom to Work (FTW) participants. This is up from 966 last month.

Paul Reinhart, Michigan Medical Services Administration (MSA) Director, has sent a letter to Gale Arden with Centers for Medicare and Medicaid Services (CMS) asking her to help Michigan resolve the question delaying CMS approval of our State Plan Amendment to allow the use of personal care services in the workplace. We await a response to determine how to proceed.

Erin Riehle with Project Search (associated with Cincinnati Children's Hospital presented at the Self-determination conference. Both the plenary and work shop were well received. She also met with small groups in Grand Rapids as well as Detroit to further plan how to create a Project Search program in Michigan. Hope Network is presently working with Erin to develop a core Project Search.

Marty has now visited over 2 dozen club houses sharing Freedom to Work and related work information. Members from nearly every clubhouse have been enthused to have current materials and to learn they can work and keep their Medicaid coverage in many different ways. Marty has been invited back to most club houses for "dinner" talks on working. In addition, a clubhouse has now facilitated having Marty meet with the local CMH Case Managers.

Joe expects to meet with United Way of Southeast Michigan by early July and discuss similarities in the MIG's efforts to explore a Michigan like " www.db101.org " site and the United Way's

interest in creating an online application/information site for individuals. These two efforts appear to be more different then alike. Joe will be talking with MRS and MDCH in July about proceeding.

Theresa is reviewing and contacting various MIG projects across the country to determine how other states have addressed specific issues being discussed between the MIG and MSA.

MIG Status Report: Barriers to Employment – June 15, 2007 ***983 FTW Members*** arinit@michigan.gov

Issue	*Explanation*	*Potential Solution*	*Action/Timeframe*
PAS/PCS Issue As of today Persons needing PAS/PCS to manage personal needs while at work cannot accomplish this.	Persons needing PAS/PCS to accomplish personal needs are limited at how long during the day they can be away from home. Because they cannot take care of personal needs at work, they end up working less or choosing not to work at all. The FTW law itself prohibits the use of PAS/PCS in the work place, ie "FTW 106a (3) - …and does not include personal assistance services in the workplace."	-Work with MSA to draft language to amend the State Plan. This will be part of our Medicaid State Plan. -The State Plan Language will override the FTW Language. -Mike, Joe and Theresa will work with MSA -If no word on SPA by Friday, June 16, Ed Kemp will initiate contact with CMS to ensure the SPA process is moving.	-MAY 09 An update was given by Ed Kemp who said that CMS wants us to re-look at the reimbursement issues. An attempt was made to try to separate these issues from the rest of the SPA and move on with the part we are concerned with which includes PA services in the workplace, but the attempt did not fly with CMS. Therefore the whole submission was pulled back in order to stop the clock so we would not have to start over. Ed Kemp stated that he wanted to get started with a committee to resolve these issues next week, he suggested a few individuals who might serve along with someone at least from our group appointed by Mike. He really didn't foresee a speedy result from this committee. When asked what advocates could do to help, Ed stated that if someone could get the grant people at CMS to talk with the contract policy people and get them to accept an expressed clear effort in the right direction as good enough, maybe that could save the grant. **-JUNE 13 Joe Longcor reported that Mike Head has finished the letter to CMS and it is in for signature by Paul Reinhart. Once signed, It will be mailed to Gale Arden at CMS.**
Case Review/Earnings Level Issue	DHS defers to PEM 260 for directive as to yearly review and PAM 815 as to guidance on the process of review. DHS Diary Date set for automatic	-Working with MSA, and DHS – MRT Division. -Short term solution "interim update" to DHS proposed.	-Feb 14, 07 This issue is still not resolved, therefore Linda is to push review dates forward for six months again. Logan will send Linda an email to see if she has

Presently, after 12 months a person earning over SGA – upon their yearly DHS case review, the person is seen as "not" disabled, and kicked out of FTW because of earnings level.	annual review of a person with a disability set at one year. The review looks at earnings, then disability. The current FTW law supports this. The FTW law states eligibility standards in 106a (2) specifically "(a)…. or would be found to be disabled except for earnings in excess of the SGA level as established by the U.S. SSA"	-Long-term procedure being determined. - Need to review cases w/out considering disability. -Need to change procedure manual (PEM) manual to disregard earnings consideration in the case of FTW participants - Jackie & Theresa assigned to work with MSA & complement process -Theresa will assure that Linda does receive copies of the documents she needs (PEM 260 & 174).	been able to complete the process. If Linda cannot get to it before leaving for her time off work, Logan will ask Anne Bialke to complete the push forward of review dates process. **-JUNE 13 Status of review dates was given by Logan. Linda is responsible for this. Also she will be the one in charge of drafting the policy change to resolve this issue permanently. This policy change is likely to be in January 2008. Logan remains concerned that just changing policy will not "catch" the FTW files that should not be reviewed. More discussion about choosing a certain color of paper to highlight the file. Joe said the MIG would buy a couple of cases of bright neon paper and paper clips to attach to the top of these files so MRT doesn't review, etc.**
Unearned Income Issue Current FTW individuals receive or achieve unexpected unearned income, placing them in a status with unearned income above FPL.	Some unearned income results as a direct benefit from working, such as: unemployment, workers compensation, and working at higher earnings, thereby increasing the amount of SSDI check received in the case of temporary layoffs or medical leave. Other factors that could cause an unexpected rise in unearned income include the death of a parent, receipt of child support, or receipt of spousal support. FTW Law 106a (2) (c) states, "The individual has unearned income level of not more than 100% of the current federal poverty guidelines." Yet this	-The benefits derived from working are received as unearned income, ie unemployment, comp pay, disability leave, etc. -The intent is not to be penalizing people who work - Theresa assisted by Joe, will develop list of items to be included in future inclusive FTW disregard for submission to Logan by June 30.	-MAY 09 Theresa asked Logan for an update on the submitted disregards. Logan stated there had been no movement on them. Theresa asked if there was anything that she could do to assist. Logan stated not at this time. **-JUNE13 Draft language of disregards was submitted by Theresa as requested by Logan. The disregards were discussed. Possible courses of action were also discussed such as using a percentage of unearned income, a percentage of COLA or other increases, or simply disregarding SSDI and SSI income altogether. Ideas were generated; such as creating a separate**

	seems to contradict with 106a (4) (c) which speaks to "temporary breaks in employment that do not exceed 24 months if temporary breaks are the result of an involuntary layoff or are determined to be medically necessary." Because of a person's past work record, the amount of unearned income collected during these temporary breaks from employment may actually bring a person above the FPL threshold and make them ineligible to participate in FTW.		**defined Medicaid program/category or waiver for PAS. Julie Dupuis and Vaishali Patgoankar will run some numbers on COLA of FPL and SSDI increases over the past 5 years to determine a comparison and an average percentage increase. Logan will strive to determine acceptable language as a disregard to address requests. We will continue to work to allow a person 65 years or older to remain Medicaid eligible as needed through FTW. We are also concerned with how to protect the NON-FTW spouse or child that has income deemed to them and may be in jeopardy of losing their Medicaid coverage.**
Aging Out Issue FTW participants approaching age 65+ accumulating resources, savings, retirement, etc. must now dissolve these resources in order to retain Medicaid eligibility.	FTW Law specifically states in 106a (2) (b) "To be eligible, "the individual is at least 16 years of age and younger than 65 years of age." Michigan's Medicaid Buy-In Law is authorized under the TWIIA, which has an age limit for participation of 16-65.	-One course of action could be to try to pass a Medicaid Buy-In under the Balanced Budget Act as other states are attempting to do. The Balanced Budget Act allows for all ages to participate but has other restrictions as to income earned and savings. -Theresa will discuss with NCHSD and look into which states either have done this or are about to accomplish the passing of both. -Theresa will follow up with NCHSD and/or Connecticut on this topic.	-April 11 Joe noted that we need to have this on the agenda for May so it isn't forgotten. Per TTWWIIA regulations, a consumer is ineligible for Freedom to Work at the age of 65. It appears to be unfair to encourage a consumer to work only to have to loose all they have gained once they reach age 65. Connecticut has resolved this barrier using the Balanced Budget Act. Theresa will pursue Connecticut's language. **-MAY 09 Theresa outlined the Aging Issue again and asked if the group was still in agreement that the solution was to use the 1902R2 to write an exception to the current policy. Logan stated that this was correct. Theresa asked what Logan needed from us to go ahead with the exception. Logan**

			said just write it up and send it to me. Tony wanted to know if we could do the same with the marriage penalty issue, and the income disregards such as veterans etc. Theresa then asked again about the listed disregards spoke of earlier. Logan responded by saying that it might be possible to include those also in one packaged disregard exception list.
Premium Issue The current FTW premiums fees are seen as "cliffs." The variance in premium amount leaves big differences from one level to the next, which can be triggered by a simple .50 cents increase in pay.	The FTW Law allows for Medicaid Buy-In premiums to be on a sliding scale. Specifically the FTW Law states in 106a "(5) (c) "the Premium sliding fee scale shall have no more than 5 tiers." An unintended consequence of setting the fee scale as MI did (using an SSI methodology for counting income) resulted in individuals having to earn around $4,000 a month before paying the first level of premium, which was set at $50.00.	- Consider a MSA Administrative Policy Change in the existing current premium fee scale. -One Suggestion includes changing to a % scale for individual income level; or go from 100% FPL To 250% of FPL to begin paying premium. - Another possibility would be to switch to a sliding scale based on percentage of countable income. -Some states have premiums that start at the point of any earnings and/or may include unearned income	-Aug 15 It was suggested that we consider using % for eligibility into the program. And it should also be noted that % was suggested here as a way to make premiums smoother from one level to the next. -Sept 12. It was suggested by Tony that we might want to look at and compile suggestions using different premium scales or methodology for premiums. Theresa will assist by providing an analysis from NCHSD on what other states have for their premium systems.
Marriage Penalty Issue The FTW participant's earnings are "deemed" to the spouse and the	The issue of deeming is a problem for FTW participants who have a spouse receiving supportive benefits, such as SSI, due to a disabling condition. A part of the working spouses' income is deemed to the other spouse. This results in the other spouses' benefits	-This is a federal challenge within SSA -The WIAG group meets in Chicago and this is a topic they are considering. Tony Wong, Karen Larsen, & June Morse participate.	-Aug 15 A question was raised, why we couldn't use the provisions in 1902 to specify this group individually, and make a State administrative rule that would eliminate the problem of deeming between spouses. Logan referred us to a piece of guidance issued from CMS that

spouse becomes ineligible for Medicaid and other supports.	possibly being reduced or eliminated.		may be of help. More research to be done in this area. Sept 12 Tony is going to write up a possible state solution to this Federal problem using the 1902 (r) (2) provisions. He would like some feedback on a document he is preparing for the WIAG committee.
Part B Premiums Issue Some FTW persons become responsible to pay the Medicare premium for Part B without being advised of this impact.	The state DHS policy FTW, PEM 174, clearly states,"a person eligible for medical assistance under FTW is not eligible for ALMB." FTW participants may be required to pay Part B costs when they achieve certain earnings levels. Currently Individuals are not made aware of this before switching to FTW.	-Theresa will further research potential implications of this factor within the FTW program -Consider whether a change in Administrative policy is needed -Need to develop method to inform participants that they may be required to pay their Medicare Part B premiums as they begin working.	-June13 MSP premiums were discussed briefly as the issue also involves concurrently eligible for ADCARE. Linda concurred with Theresa's findings that people did not have to pay Medicare Part B premiums because of switching to FTW, but because of a rise in their income as a result of working. -Jan 10 We acquired information at this meeting that there is a new sliding scale to part B premiums with costs starting at $93.60 plus $12.50 and with a scale going up from there. At this time there doesn't seem like there would be an impact for our current FTW participants, but that may change if and when we have participants in the higher income brackets.
Waiver Issue People are asking about being in FTW while using waivers.	People want to be able to remain within a waiver, work, and participate in FTW, but they have been told they can't. People prefer waivers because of the PSA/PCA services. Waivers have a higher income limit to be economically eligible than other Medicaid programs. FTW is an eligibility category and by using the "Freedom Accounts" a person should remain or be eligible for the MI Choice	-Discussed with Pam McNabb & Jackie Tichnell. Eligibility would depend on slots and earnings? - Mike Head noted that FTW was an eligibility Category, whereas the MI Choice waiver is a Program Category. -May 18…Jackie forwarded an overview of why we believe FTW should be able to work in conjunction with this waiver	-Jan 10, 07-Mike Head met with Ed in December to address this. Logan did not know if this had formally been addressed. Joe will check with Ed. -Feb 14, 07 We can now celebrate success on this issue. People can now participate in both the waiver and FTW at the same time. Joe presented a copy of a memo to the waiver agents giving them direction on the new policy.

	Waiver.		
Economic Earnings Issue SSDI recipients that are FTW enrollees remain discouraged from earning over SGA until a person can minimally replace their SSDI check. Ties into the Federal SSA action on SGA. People are unlikely to work in order to have less $ in their pockets.	People with disabilities work to make money just like anyone else. Individuals are commonly unwilling to accept work that won't minimally replace their check. It costs PWD money $ to work, in some cases people with disabilities incur large expenses in order to work. In addition, individuals remain concerned of the future need of medical coverage. Some progress has been made in this area through the TWIIA and reinstatement of benefits provision within.	-Need to do research on what it would take to eliminate SGA and allow persons to wean off benefits slowly. -Work with the MI JOB Coalition and others working towards a solution to the issue of SGA - PWDS need to gain skills to qualify for a higher paying job, so they can earn enough to take the leap of faith off the system.	-Feb & April "Think Work" summits suggest growing effort by Mi Jobs Coalition to seek demonstration/pilot grant from SSA to disregard SGA as a standard for persons with SSDI.
Deductible Issue As of January 2004, PWD may have been put into Spend-Down eligibility category (now referred to as the Deductible Program) instead of being referred to the FTW eligibility category.	As of January 2004 through August 01 2005 (Prior to the institutionalization of the LAO2 prompt), PWD may have inadvertently been put into spend-down (now referred to as the Deductible Program) when applying for Medicaid benefits because of having earned income combined with unearned income that placed total earnings over the FPL. Some of these individuals should have been FTW participants.		- July 13 Concern was expressed as to what if anything can be done to capture persons who were missed. -Aug 15 Additional discussion occurred. No action -OCT 10 There was some discussion as to what/who this population is. Linda Kusnier is working on the December 2003 persons that were spend down prior to January 2004 and would have been FTW persons except for the implementation date. Tony was thinking this was the same group of persons. Logan will pursue with Linda

AD Care Issue PWDs that come in to apply for Medicaid and are working below 100% FPL are automatically referred to AD Care.	It is the policy of DHS to place eligible individuals into the most beneficial MA category for the person. Yet, <u>some individuals with disabilities who have jobs and are actively working are placed into ADCARE rather than FTW.</u> These individuals have a combined income below FPL. The benefit of placing working PWDs to FTW would increase the program enrollment numbers and bring more federal grant dollars to the state ultimately providing greater opportunities to individuals with disabilities.	-Take a look at DHS policy and procedures and determine if changes are needed. If so, make recommendations to MSA. Theresa and Jackie -Study the challenges of transferring working persons with disabilities from ADCARE to FTW to be sure that no harm would occur (recall that some would then need to pay the Part B premium of $88.50/mo.) *People will only have to pay their Part B premium as their income rises above the poverty level. At that point they would no longer be eligible for ACARE or the Medicare subsidy because they would be over income.	-<u>May 09</u> Logan Dreasky stated that there just was not the manpower to get the 6000+ transferred in the near future, but he did feel that the original 600 from the list that Dan from DHS came up with on the original list, who were erroneously in ADCARE have to be moved right away. The action would be handled by MSA personnel, although in the immediate future they were busy crunching numbers for the budget. Even so, Logan stated that he has the original hard copy around somewhere and that this could probably be done soon, about two months time. I said, "So then, we can expect that it will be completed by August 2007?" No response was given on commitment. One idea expressed as to getting the others transferred over was to have the MIG fund a staff position for a while to move the 6,600 ADCARE to FTW. This was just an idea that was suggested and discussed as a possibility to make the process more doable. **<u>-JUNE 13</u> Present status on the time table for moving the 600-700 from ADCARE to "Freedom to Work". After a preliminary review, DHS doesn't like the letter. The letter is currently with Michelle, and then it will go to Lou of Outstate operations. At this time we are waiting for comments on the letter and/or the process to come back to MSA.**
Freedom Accounts Issue	The advantage to Freedom Accounts is that <u>PWDs can set aside income to</u>	-Determine how to build awareness among FTW enrollees	-<u>Aug 15</u> Theresa reported that she has located within the PEMs a DHS Form that

FTW enrollees are not aware of Freedom Accounts and commonly don't know the benefits of utilizing these accounts to build savings or increase earnings.	save for things they need, and still qualify for Medicaid benefits and medical coverage under the MA program.	to promote increased earnings & savings while retaining needed benefits.	will serve the purpose of designating freedom accounts by consumers of DHS services. She also has drafted new PEM language and directions for the use of this form. Theresa is in the process of going through the PEMS to see where modifications need to occur to affected PEMs, and is drafting a memo on this to be submitted with the suggested changes. -OCT 10 Theresa shared a draft Bulletin announcing this policy. She provided Logan with a copy. MSA will review and provide the office with comments. Tony suggested adding a section on consumer responsibilities and consequences to the bulletin and the brochure he is working on. Theresa suggested modifying DHS Form 503 Asset Verification Form to include designation for Freedom Accounts, creating a new DHS Form for FTW. A suggestion occurred to modify the FTW DHS Form since Freedom Accounts can also include money from income. Make it a similar but New Form with its own Form Number.
SSA 1619 transition to FTW Presently smooth transition to FTW is not assured.	Persons presently in 1619 status may earn or save their way onto FTW, but are fearful to take that leap because they are unsure that transition into FTW Medicaid will be a seamless process.	-Research possible ways to address MA policy to allow this transition to be seamless.	-TBD
Working from Home and HUD Housing	Persons living in HUD housing are told that they cannot engage in business activities out of their home. This severely limits some employment opportunities for PWDs.	-Theresa will check HUD policy and also with a few contacts she has within the advocacy field that often helps PWDs with housing issues regarding subsidized	-June 16 Ref Jackie Blankenship (MSHDA) thru Sue Eby (MDCH) thru Glen Ashley (MDDC-MDCH) **HUD Regulations:** 24 CFR 982.551 Obligations of Participant states

		housing.	
Michigan First - Health Care Program	Does this new waiver have any impact on the Freedom to Work Program?		-July 13 Jackie Tichnell contacted Susan Yontz. What we know so far is that it is an 1115 waiver, there is no draft available to share, and there is no template. Susan will let people know that we are interested in learning more information and she will get back to us. -August 8 Theresa has done some research into this and drafted a memo giving the message that from all materials so far there appears to be no adverse effects to FTW participants. This new MI health program may in fact offer health care to people with disabilities who wouldn't otherwise have access to health care.
FTW training in DHS offices (and elsewhere) to NOT include References to not being on a Spend Down/ Deductible.	The current training module used by DHS makes reference to FTW not being for people on the deductible Medicaid program.	The fact of people being on a deductible being the reason for exclusion from FTW is really not true. The qualifying eligibility criteria used for FTW is the same as for ADCARE eligibility, using an SSI category income breakdown.	
Issue regarding the use of or Lack of use of IRWEs by PWDS due to many systemic problems.	1. There are no clear rules or process available to the public or with in the SSA Department that persons can use as guidance in determining whether they have potential IRWEs. 2. When PWDS who are aware of the POMS or are working with a knowledgeable Social Worker and therefore they have a list of IRWEs to turn in. They are treated as if they	There needs to be an administration process and documentation flow process put into place here. Along with an appeals process. The lack of these things clearly shows why the numbers are so low in people using IRWEs.	

	are stealing or trying to get something they don't have a right to. 3. When PWDs are working with knowledgeable WIPAs etc. and turn in there IRWEs, they receive no correspondence or feedback from SSA. And on most occasions no one even applies the IRWES to the case. And if SSA does. SSA never tells anyone.		
FTW and Family Size Eligibility Issue	When FTW eligibility is considered for people with disabilities, we look at the individual. The issue of what is the individual is a member of a family of two and the working spouse is currently receiving Medicaid under ADCARE or some other category?	-We need to decide if we can look at family size relative to income eligibility. -We need to consider the impact on other people who now may be eligible where they were not before.	-March 14, 07 Mr. Steve Fitton , and Mr. Paul Reinhart, and Ms. Jackie Doig were guests at the meeting this day to discuss this particular issue as it arose with a married disabled consumer who wished to be in the Freedom to Work category. Currently, he receives Medicaid through the ADCARE category. Between the consumer and his spouse their combined income is under the FPL income level for a family of two. Although the individual alone has unearned income above the FPL for an individual. The question was raised of whether or not to allow an individual who meets the 2 per person standard of unearned income less than 100% of FPL criteria into the FTW category. Paul supported it. Steve said he also would support it, but he would like to see some documentation on the implications of allowing this. Logan said that this would cause some issues with the way the law is written and with CMS and the State plan. **–** **June 13** FAMILY SIZE: Status on process/ procedure allowing a person to be eligible based on family size. Ed said

			it involves systems and timing – Logan informed us MSA is shooting for a January 2008 policy date. **Theresa will also forward the Medicaid Buy-in comparison chart of all states to Ed Kemp and others to consider how states may be addressing eligibility challenges.**
People Dropping Out of FTW….Why?	People deciding that they don't want to participate in Medicaid for whatever personal reason they may have.	Attend existing community gatherings the consumers and their families/support persons attend. Ask Why? -Was the program difficult to participate in? -Were the rules too difficult to understand? -Was there no one to explain the program or help with paperwork? -Did they receive Benefits counseling/ If so, was it helpful? -If not? Why Not? -Did they not trust the program would work for them?	
Migration Issue (*People moving out from one county and into another to become a Medicaid Beneficiary*)	-People will migrate to counties based on the way DHS policies are applied to cases. -For example. An individual w/disabilities since birth; Medicaid eligible since birth; moves to another county and has case transferred. They are planning to stay in new county for awhile. (Cheap Rent). Person soon discovers that in new county they are not eligible. Why?	-Cost of Living varies from county to county. DHS Budgeting process for each county is based on the COL for that county. Therefore the individual may or may not be a recipient of the same benefits from county to county.	

Self- Determination in Long Term Care Project
June 2007

The majority of the energy for the Self Determination implementation has been on training. We have trained more than 350 in over 10 sessions in the past month. The biggest trainings were for the waiver agents who are not Pioneers. We were in Ann Arbor, Gaylord and Kalamazoo talking about Person Centered Planning and reviewing the draft guidelines. This is the foundation for the change for the waiver agents before Self Determination is implemented.

We are also conducting PCP audits for the Pioneers. This involves reviewing case files, speaking with consumers and interviewing management about the Person Centered practices in each agency. So far, we have been to Detroit AAA for this.

We are scheduling conference calls for the wavier agents in July. **CTF members are welcome to call in.** All calls begin at 2 pm e.s.t. until 3:30. A self determination participant will be featured in each call.

July 10 – Program overview, questions and answers
July 17 – Participant/Consumer involvement
July 24 – Organizational Readiness
July 31 – Enrollment issues and process

The call in number is 877.336.1828 pass code 7527039

Next steps for the rest of the summer include more training on the actual processes of Self Determination. We will be back on the road training in late August. The curriculum is being developed. **It is critical that we have consumers present at these trainings, particularly MI Choice participants.** It helps

remind folks why we are doing this work and gives them an opportunity to learn from someone who is not their “client” in a non-threatening manner. **If you are interested in being part of this training, please let me know. Stipends are available for participation.**

Other details to finish over the summer include drafting a Self Determination practice guide line and an operation manual. Expect to see drafts of these for your input at the next meeting.

Contact me anytime to get more information.

Michigan LTC Connections
June 2007

Vision

Each LTC Connection site is a highly visible and trusted source of information and assistance about long-term care, aiding Michigan residents with planning and access to needed services and supports, in accordance with their preferences

1. The contracts to the Area Agencies on Aging have been cancelled. Most of the new contracts to the LTC Connections have been sent to the agencies for signatures. The Detroit LTC Connections should be ready soon. There will be a 30-day overlap of functions and personnel for transition to the new entity.

2. The Evaluators and the Quality Management Subcommittee developed a draft of the Information and Assistance consumer experience survey and protocol. It is being circulated for feedback, and will be pilot tested over the next 5 weeks or so.

3. A document that identifies each of the LTC Connections governing and consumer advisory boards is being prepared. Responses are due from the LTC Connections June 20th.

4. A contract has been signed with the Michigan Public Health Institute to provide the independent evaluation of the demonstration sites.

Independence Plus and
Money Follows the Person Grants
June 2007

The 2007 Michigan Self-Determination Conference was held on June 11 & 12 at the Lansing Holiday Inn South. This was the 10th annual state wide conference. Some of the preliminary summary figures are:

Total number or registrations processed = 544
Total number of cancellations/replacements = 28
Total number of no-shows = 21
Total number of walk-in/onsite registrations = 22

Total number of scholarships = 29
Total number of Presenters = 67
Total number of MACMHB staff = 6

Administrators	57	0.14
Case Managers/Supports Coordinators	51	0.12
Professional	34	0.08
Family Friend	19	0.05
Consumer/Self-Advocate	152	0.36
Personal Assistant	21	0.05
Advocates	9	0.02
Micro-Enterprise Attendees/Exhibitors	47	0.11
Other	30	0.07
Total (incomplete data)	420	100%

- Materials from the Consumers as Employers, from the Paraprofessional Healthcare Institute course on "**Employing, Supporting and Retaining Your Personal Assistant"** can be found at this web address. http://198.109.129.5:3455/sdl/74

- The booklet written by Ellen Sugrue-Hymen, called **"Hiring and Managing Personal Assistants"** has been printed. This resource is intended for persons with disabilities and others in Self-Determined arrangements who hire their own staff. Copies can be requested through The Arc Michigan.

- Combined 1915bc Waiver Development
  - An internal draft of a concept paper describing the scope, purpose and methods for a cost neutral Medicaid benefit in one or two counties in support of community living options for elders and persons with disabilities is being developed. This document was sent to the CMS but there has been no response at this time.
  - Meetings have begun on the feasibility study for the waiver.
  - The waiver request is scheduled to be completed by October 1, 2007.

- A no-cost 6 month extension request has been approved by CMS for the 2003 Money Follows the Person grant. The extension period is for October 1, 2007 to March 30, 2008. This extension provides support for continuing development of the 1915bc waiver request and for the development of the proposed providers.

- The next meeting of the Self-Determination Implementation Leadership Seminar will be on July 10th. At the Lansing Holiday Inn South. The meeting is from 8:30 to 3:30. Consumers are invited to attend on a complementary basis. Registration is through the MACMHB at (517) 374-6848 or through their website, www.macmhb.org

- The Person-Centered Planning in Community Based Long-Term Care Practice Guideline Review Draft was sent to a large number of individuals for their comments. The comments are due back on July 9th.

LTC Supports and Services Commission
June 2007

Report from 5/21/2007 meeting

The Commission received an update on Office activities and the budget situation. Steve Fitton from the DCH Medical Services Administration explained the 6% across the board reduction in fees, recognizing that it was not good policy but rather necessary to balance the budget in the absence of further direction from the Legislature regarding the budget. The fee reduction does not affect the nursing facility transition services, MI Choice special MOUs, the personal care supplement paid to AFCs and HFAs, or private duty nursing services.

Update: The 6% reduction has since been rescinded by MSA. No cuts will be made to Medicaid programs at this time.

The Commission discussed their various workgroups, including identification of members, charges, and tasks as they relate back to the Task Force recommendations. The following workgroups are being convened, by the indicated chairs:

a. Workforce – Chair: Hollis Turnham
b. Prevention – Chair: RoAnne Chaney
c. Finance – Chairs: Christine Chesny, Jon Reardon
d. Quality – Chair: Sarah Slocum
e. Public Education – Chair: Toni Wilson, Robert Allison
f. Person-Centered Planning – Chairs: Dohn Hoyle, Denise Rabidoux

Individuals who wish to participate in the workgroup process should contact the chair.

Public comment was provided by two individuals:

Robert Stein of the Michigan Assisted Living Association, commented about the need to include licensed specialized residential settings for MIChoice services.

Sara Duris of the Alzheimers Association commented on the growing need for quality dementia care. There are new facts and figures at their website: www.alz.org.

The Commission encourages their constituency at the grass roots level to provide comments and reactions to the budget issues among other issues.

Next meeting: July 23, 2007
Capitol View Building, Conference Rooms A-C
1:00 – 4:30 p.m.

Systems Transformation Grant
June 2007

On 6/15 we submitted the revised strategic plan based upon feedback from CMS. There were not any substantive changes from our original submission. The next step is to assemble a workgroup to refine the evaluation plan. We submitted a draft evaluation plan as part of the strategic plan. We now have until 8/3 to expand this with additional detail. The workgroup will draw members from the three workgroups that developed the strategic plan. The Project Director position is being processed as an exception to the hiring freeze and we hope to have approval to hire in the near future.

Deficit Reduction Act/Money Follows the Person
June 2007

We continue to work on the Operational Protocol, which we plan to submit to CMS by August. We will be assembling a stakeholder group to provide input to this document. The Project Director position is being processed as an exception to the hiring freeze and we hope to have approval to hire in the near future.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

June 6, 2007

Dear Colleagues and Interested Parties:

I would first like to applaud the efforts of the workgroup that developed the proposed draft "Person-Centered Planning for Community Based Long-Term Care: Practice Guidelines" document. This document identifies features of person-centered planning within the context of the current MI Choice Medicaid waiver program in Michigan.

A key first step is to make person-centered planning a part of the contract requirement for the MI Choice Medicaid waiver program. Toward that end, we are sending this draft document out to a broader audience of consumers, advocates, agency staff and DCH employees for review and comment regarding its content. We would like to collect any specific or useful information that you feel should be included as part of the practice guideline.

The deadline for submitting comments is Monday, July 9, 2007. Please provide your feedback using the tear-off sheet located at the end of the document.

We sincerely hope the final practice guidelines proves helpful in implementing a planning process that best supports the needs of individuals participating in the MI Choice Medicaid waiver program.

Thank you for your participation in this review.

Sincerely,

Michael J. Head, Director
Office of Long-Term Care Supports and Services

Michigan Department of Community Health
Office of Long-Term Care Supports and Services

Person-Centered Planning for Community Based Long-Term Care

Practice Guidelines

REVIEW DRAFT
June 6, 2007

"Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Final Report of
The Michigan Medicaid Long-Term Care Task Force Report
May 2005

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May 2005

I. Purpose

This document provides guidance and technical assistance on how to successfully implement the person-centered planning process with individuals participating in the MI Choice Medicaid waiver program. The person-centered planning process is intended to become a contract requirement for MI Choice waiver agents, which provide community-based long-term care services to people who are aging or have disabilities.

The Michigan Department of Community Health, Office of Long-Term Care Supports and Services has convened a discovery and training process for MI Choice waiver agents and the long-term care community as a whole to identify exemplary practices in person-centered planning. These practice guidelines are an outcome of that process.

The person-centered planning process ensures that individuals who need long-term care supports and services have a method for identifying their goals and preferences and the necessary supports and services. The process supports planning for needed long-term care supports and services in ways that best enable the individual to acquire and maintain his/her life in a community setting, assure his/her desires to maintain or increase their quality of life, and at the same time address health and welfare needs.

In the person-centered planning process;

- Individuals know their options,
- Individuals make their own decisions,
- Individual decisions are driven by their life goals and priorities,
- Individuals have the support of allies in planning, developing, and implementing their supports and services.

II. Person-Centered Planning Process Definition

As defined by the Michigan Medicaid Long-Term Care Task Force in their final report, "Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

The person-centered planning process can also quickly adapt to changing needs and desires. Often, individuals select allies to become involved in the person-centered planning process; these allies may include family, friends, professionals, or caregiver staff. The involvement of allies is the choice of the individual. Some individuals will choose not to involve any of their allies or will invite only one or two people to participate. Professionals, who have traditionally been involved in the planning and delivery of services, may have a role in the person-centered planning process and their recommendations and assessments may be used in the planning process. The supports coordinator must be involved because he or she is responsible for authorizing the service plan. However, the development of the service plan, including the identification of possible supports and services and providers, is based on the expressed needs and desires of the individual rather than the recommendations of the professionals.

The individual's choices drive an ongoing process of setting goals (such as where they want to live, how they want to connect with others, the activities in which they want to participate) making plans, selecting supports and services, evaluating progress and outcomes, and revising or setting new goals. The goals and identified supports and services are incorporated into a service plan that includes both paid supports and services (such as MI Choice waiver services) and unpaid support (such as support provided by a spouse) that shapes service delivery implementation and is revised as needed.

III. Background

A. Shifting to a Person-Centered Model

The role of long-term care services is to assist individuals in meeting their health and welfare needs. Historically, long-term care service delivery has been based on the

medical model, which focused on treating the health condition of concern. Medical professionals made decisions about treatment and service settings. The setting for long-term care was typically the nursing home. Federal regulations favored this approach. Recently, other community alternatives became more available.

B. History of Person-Centered Planning in Michigan

The movement toward person-centered planning has been growing in Michigan for the past two decades. Originally, person-centered planning was developed as a method for working with persons with developmental disabilities to identify their dreams, goals, and desires.

As the concept was introduced in Michigan in the late 1980s and early 1990s, the independent living philosophy was incorporated into the person-centered planning process so that the individual could use this process to acquire the life he or she chooses in the community with work, meaningful activities, friends and relationships, and other means of community involvement, just like everyone else. In 1996, legislation was passed that required individuals receiving supports and services in the public mental health system to develop an individual plan of services using a person-centered planning process. In the last ten years, individuals with developmental disabilities and/or mental illness have used this process to pursue their goals to live, work, and be involved in the community with the support they need and want.

C. Person-Centered Planning in Long-Term Care

The philosophy of person-centered planning has been embraced statewide as the method for individuals who need long-term care to plan for supports and services to enable them to maintain their lives in their homes, neighborhoods and community, and to maintain or obtain connections with other community members. Michigan Governor, Jennifer M. Granholm, issued Executive Order 2004-1 to create the Medicaid Long Term Care Task Force to study long-term care in Michigan and identify consensus recommendations to design an effective and efficient system of long-term care supports and services. One of the Task Force charges is to "Examine and report on the current quality of Medicaid long-term care services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan." Moving forward

with the Governor's charge, the report identified person-centered planning as a central policy recommendation to, "use person-centered processes and tools to assess and match the individual's needs and desires across a continuum of LTC services based on demonstrated need, effective individualized management and care planning."

The other eight recommendations focus on individual choice and control by making available a continuum of long-term care options, increased awareness and information, options for arrangements that support self-determination, and a well-compensated workforce.

D. Person-Centered Planning and Self-Determination

Person-centered planning is a method for identifying an individual's needs and desires and to make meaningful choices regarding their lives. Self-determination is the belief and value that individuals who need supports and services have freedom and authority to manage their individual budget and directly employ or contract with their service providers. All people who are receiving MI Choice waiver services have the right to develop their supports and services through the person-centered planning process. By the end of 2007, individuals receiving services from any waiver agent in the state also will be able to choose to participate in the Michigan Self-Determination in Long-Term Care program. The program enables individuals to choose and employ their own providers including personal care workers, and to manage the individual budget authorized by the waiver agent.

IV. Implementation of Person-Centered Planning

A. Person-Centered Planning Values and Principles

Person-centered planning is an individualized process designed to respond to the expressed needs and desires of the individual.

- Each individual has strengths and the ability to express preferences and to make choices.
- The individual's choices and preferences shall always be honored and considered if not always included in the plan due to health and welfare concerns or budgetary restraints.

- Each individual can contribute to the community, and has the ability to choose how supports and services may help them meaningfully participate in and contribute to the community.
- Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals, and desires.
- A person's cultural background shall be recognized and valued in the planning process.[1]

B. Essential Elements for Person-Centered Planning

There are a number of methods available to accomplish person-centered planning including, but not limited to: Individual Service Design, Personal Future Planning, MAPS, Essential Lifestyle Planning, and Planning Alternative Tomorrows with Hope. This document does not endorse any particular method or model. Regardless of the model used or whether a formal model is used at all, the following characteristics of person-centered planning are essential to the process of planning with an individual and his or her allies:

1. Person-Directed. The plan for the individual is the individual's vision of what he or she would like to be or do. The plan is not static, but rather it changes as new opportunities and challenges arise.

2. Capacity Building. Planning focuses on an individual's gifts, talents, and skills rather than deficits. It builds upon the individual's ability to engage in activities that promote a sense of belonging in the community.

3. Person-Centered. The focus is continually on the individual for whom the plan is being developed and not on fitting the person into available slots in a standard program. The individual's choices and preferences must be honored. If the individual does not communicate verbally, the process accommodates him or her to ensure that the individual's choices and preferences are honored. Guidance on behavior as communication is provided below.

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[1] Adapted from Person-Centered Planning Policy and Practice Guideline, Michigan Department of Community Health, October 2002.

4. Network Building. The process brings people together both to support an individual (by involving allies in the planning process and honoring their role in the individual's life) and to support the larger community (by involving community members and by providing a mechanism for individuals receiving services to connect with one another and with community members as desired).

5. Outcome-Based. The plan focuses on increasing any or all of the following experiences, which are valued by the individual:

- Growing in relationships or having friends.
- Contributing or performing meaningful activities.
- Sharing ordinary places or being part of their own community.
- Gaining respect or having a valued role that expresses their gifts and talents.
- Making choices that are meaningful and express individual identity.
- Addressing health and welfare needs.
- Planning for end-of-life support, when necessary.

6. Community Accountability. The service plan will assure adequate supports when there are issues of health and welfare needs, while respecting each individual and his or her dignity as a participating member of the community.[2]

7. Presumed Competence. Person-centered planning is based on the premise that everyone has preferences that can form the foundation for how they want to live their life and what their dreams, goals, and desires are. The focus is on these preferences instead of on an individual's disabilities, deficits, or level of capacity. In fact, all individuals are presumed to have the capacity to actively participate in the planning process. As described below, it is incumbent on the supports coordinator and the individual's allies to find a method to communicate with the individual and discern his or her preferences.

8. Information and Guidance. When an individual is planning for arrangements that support self-determination, the person-centered planning process must address the individual's need for information, guidance, and support. Information and guidance may relate to the person-centered planning process, options for supports and services, or it may directly relate to a particular need of the individual (such as what living situation would best meet the individual's needs and desires, what activities does the

[2] Items #1-6 were adapted from resolution adopted by the Howell Group of Michigan, October 1994

individual wish to pursue, what strategies are needed to build, rebuild, or maintain relationships, what are the implications and consequences of a particular choice, or in what ways could the individual become involved in the community). Information and guidance is essential during the planning process, and may also be needed as service and supports are implemented.

Options should be drawn as broadly as possible from the ranges of long-term care services and generic community supports. Individuals must learn about options in ways that are useful to them. For some individuals, it may be sufficient to provide a written description of services at the beginning of the person-centered planning process or when seeking information about an option. Other individuals may need to learn about options through explanation, observation, or experience. The individual may need to try an option before making a decision. The timing for the learning and decision-making processes might need to be closely aligned.

9. Participation of Allies. For most individuals, the person-centered planning relies on the participation of allies chosen by the individual because of their commitment to support him or her. Most people living in their community already have the involvement of family members, friends, and peers. An individual may choose these people as their allies. Individuals may also have important relationships with paid personal assistance workers or other professionals. Each individual's situation and relationships are unique. Some people will want to seek out allies; others will choose to use the person-centered planning process without them. The individual determines who is an ally, and may exclude family members or friends for various reasons.

The participation of allies is important for broadening the planning input and sources of support. Allies can help individuals explore their options, articulate their vision of a desirable future, make choices for the future and find ways to solve problems. Chosen allies can be very helpful to the individual and to the supports coordinator in assisting and supporting the individual on a continuing basis as needs arise. Together, the individual and his or her allies learn together and invent new courses of action to make the vision a reality. Individuals who cannot identify family members or friends to participate should be offered support for cultivating allies who can provide this very critical assistance.

10. Documentation. The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan. The individual should be aware of and approve all distribution of planning documentation.

V. Practical Considerations in Person-Centered Planning

A. Planning for Health & Welfare

The service plan and person-centered planning process must balance health and welfare issues with the individual's right to make his or her own choices. Specific issues of health and welfare must be examined and addressed so that individuals will not find themselves in a situation where he or she is at imminent risk. The supports coordinator is responsible for ensuring that issues of health, safety, and welfare specific to the individual are discussed and resolved through the person-centered planning process. Solutions must assure the health and welfare of the individual in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction.

Typically, an important need is for a workable back-up system to provide support in the event that providers are unable to be present for a work shift or duty. There are a variety of ways to structure a back-up plan that meets the needs of the individual, with his or her supports coordinator and allies.

An individual may choose to address a sensitive health and welfare issue privately with the supports coordinator, rather than within a group planning process. Regardless of how it is done, the supports coordinator has an obligation to ensure that all health and welfare issues are addressed. When the individual makes a decision contrary to the supports coordinator's or another professional's recommendation, the supports coordinator must ensure that the individual has information about all available options, document the individual choice, and revisit the issue as needed.

Sometimes, an individual's choice about how supports and services are provided cannot be supported by the MI Choice Waiver program because the choice may pose an imminent risk to the health and welfare of the individual or others. However, these decisions are made as part of the planning process in which the individual and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the individual's needs and satisfies their dreams and goals.

B. Person-Centered Planning and Aging

The person-centered planning process was originally developed and implemented with

people with developmental disabilities. Often these were young people who were planning their whole life; the type of work or meaningful activities in which they would participate, where they would live, and how they would develop friends and relationships.

Unlike younger people, older individuals have a whole lifetime of choices behind them. They have established a residence, chosen a career or life activities, found hobbies or other meaningful activities, and developed friendships and relationships. Even when a person is unable to communicate because he or she has developed an incapacity, this lifetime of choices can be used to discern preferences and priorities. When a person is unable to communicate, life choices can be identified from the individual's surroundings (the presence or absence of photos, or the display of artwork, crafts, collections or awards).

Often, planning with older people focuses on how they can maintain or accommodate their current life. For example, an individual may need personal care or environmental modifications to be able to stay in his or her lifelong home. A person who no longer has the strength or energy to pursue their lifelong hobbies may choose to explore new pastimes.

When a person is in the later stages of life, the challenge may not only be preserving and extending the sources of joy. The individual may need support with a source of frustration or sadness—for example, grieving a deceased spouse or healing a broken or strained relationship with a family member or friend.

For individuals who are dealing with end of life issues, the planning process may involve where an individual wants to die, who they want to be with them, or who they don't want to be with them when they die. Other issues to consider could be what kind of life-sustaining treatment they want or do not want, and what measures they need to make them as comfortable as possible. The planning process may include a variety of ways to help an individual come to terms with the dying process and obtain needed closure.

C. Behavior as Communication

Supports coordinators ensure that the individual has the chance to ask questions and the options and choices clearly explained and thoroughly discussed. If the individual

needs help understanding something or communicating thoughts, the individual, with his or her allies and/or supports coordinator must determine the best way to facilitate the individual's participation in the discussion.

People with disabilities communicate in a variety of ways. Some people use technology, others use hand signals, some use their voice, and others use picture systems. Some people can only signal yes or no using movement of their head, a hand, or another part of their body.

All people communicate through their behavior. For individuals who do not have other means of communication, behavior may be the primary means of communication. For many people who use behavior to communicate, their behavior may be seen as negative (they may yell, throw an item they do not want, throw a tantrum, or become aggressive).

Supports coordinators and allies must learn to interpret an individual's behavior to determine what he or she may be communicating. Some behavior communicates emotions such as fear, discomfort, anger, or dislike. Other behavior communicates that the individual has a certain need or request or may want a certain solution or result. The behavior is unique to the individual. Efforts must be made to understand the communication and to find positive methods for the individual to communicate.

D. Involvement of a Designated Representative

Sometimes, a person may wish to designate an ally to help him or her in the planning process. An individual who does not have a guardian may designate another person to help him or her with the person-centered planning process and in implementing the supports and services chosen in that process. Selecting a personal representative may be done formally by executing a power of attorney, or informally by asking the representative to serve. Through the person-centered planning process, the individual and his or her allies may determine the best person or persons to serve as representative. A representative must be able and willing to honor the choices and preferences of the individual and support him or her to take an active role in the process as possible. In the event a personal representative is working counter to the individual's interests, the supports coordinator is authorized to address the issue and work with the individual to find an appropriate resolution.

E. Individual Monitoring and Evaluation of Progress and Outcomes

Just as the individual chooses his or her goals and the supports and services needed to achieve them, the individual should also evaluate progress toward those goals and the outcomes of the service plan. The supports coordinator can support the individual in this evaluation process (evaluation questions and surveys include standard ones required by the waiver agent or individual ones developed by the individual during the person-centered planning process); they can be simple or lengthy. Evaluation may lead to reconvening the person-centered planning process to modify the service plan or resolve a challenge that has arisen.

F. Independent Facilitation

An independent facilitator is a person chosen by the individual to guide him or her through the person-centered planning process. An independent facilitator may be a family member or friend or may be an advocate recommended by a friend, provider or supports coordinator. Whether an independent facilitator is used and whom the individual chooses for independent facilitation is up to the individual.

The individual may use an independent facilitator if he or she wants or needs to have someone that assists the individual and advocates for the individual's dreams and goals. Some individuals find it helpful to have a person involved who is outside of the waiver agent and does not make decisions to authorize supports and services and funding. Other individuals like having assistance in arranging the details of the meeting or leading the meeting. An independent facilitator can do one or all of these tasks.

The independent facilitator helps the individual with the pre-planning activities for the person-centered planning process. These activities include who will be involved, the topics to be discussed, and the individual's goals and objectives. When the individual chooses to involve an independent facilitator, the supports coordinator may not be involved in the pre-planning process. The facilitator serves as the individual's advocate throughout the process, making sure that his or her needs and concerns are heard and addressed.

VI. The Steps of Person-Centered Planning

A successful person-centered planning process puts individuals in charge of their own lives and planning, focuses on strengths, skills and/or life accomplishments, and

acknowledges and honors individual preferences. A supports coordinator supports, guides, informs, and assists the individual in learning about the person-centered planning process and assures that the individual controls the person-centered planning process. The planning process is not a single meeting. The individual may have a meeting every year, or more often, if needed. The individual may call a person-centered planning meeting every time his or her wants and needs change.

Step #1 – Initial Contact & Getting Started

The person-centered planning process begins as soon as the individual enters the long-term care system and continues as the individual seeks changes. A supports coordinator chosen by the individual helps him or her navigate through the full array of services, supports, settings, and options. The supports coordinator ensures that the individual is provided with information regarding choices the individual can make. The supports coordinator provides information on the option for independent facilitation. Even if the individual chooses an independent facilitator, the supports coordinator is involved in the person-centered planning process and authorization of supports and services paid for by the waiver agent.

Often individuals enter the long-term care system in a medical or other crisis. In those situations, immediate steps are taken to resolve the crisis and stabilize the individual's situation. Person-centered planning can begin only after the crisis is resolved.

Step #2 – Pre-Planning

Individuals must have opportunities to prepare for person-centered planning process. This includes understanding the purpose, key aspects of the process (e.g. roles of the meeting participants, discussion questions for the meetings), and the options under consideration. The individual can choose to do a pre-plan with his or her supports coordinator, an independent facilitator or a trusted ally or allies. Preparation should occur in ways that are effective for the individual, which may include a planning meeting or meetings, role-playing or practice sessions, written information or other methods.

- **Scope of the planning.** The individual determines the scope of the planning. Person-centered planning generally asks the person to think broadly about dreams, goals, and desires. However, an individual can choose to talk about a specific topic,

or challenge or even what is working or not working in his or her daily life. Both can improve an individual's quality of life and ability to maintain a life in the community.

- **Relationship between person-centered planning and service plan.** One implication of the broad scope of person-centered planning is that it informs service or care planning; that is, the individual's life plans should give direction to supports and services that the individual needs in order to realize his or her goals. The person-centered planning process is also the way the individual determines the type of supports and services he or she needs that are authorized and paid for by the waiver and who will provide the services and supports. This plan is called a service plan**.** The purpose of the plan is to help the individual to be as independent and self-sufficient as possible and build ways for them to participate in their community as desired. These supports and services include Medicaid covered services, waiver services, and services available from other government programs. The service plan must contain the date the service is to begin, the specified scope, duration, intensity of each service, and who provides the service. The individual's plan may also include informal supports that family and friends provide, as well as supports and services from other government programs.
- **Individual control over the planning process.** The individual's choices include choosing the meeting participants, participant roles (e.g. who will facilitate), location, schedule, and meeting agenda. The site and time of the meetings should accommodate the individual and key allies. The agenda should include issues the individual wants to discuss, and it should exclude issues the individual does not want to discuss.

Topics for Pre-Planning

In pre-planning, the individual should think about and choose:

- the dreams, goals, desires, and the topics the individual wants to talk about at the meeting,
- likes and dislikes, and what the individual would like more or less of in his or her life, and what the individual seeks to change,
- fears or concerns the person identifies as topics for discussion,
- topics the individual does not want talked about at the meeting,
- who, among their friends, family members, professional providers, staff, and

fellow community members the individual wants to invite to participate in the person-centered planning process,
- where and when the meeting will be held,
- who will lead the meeting and the discussion (the individual may want to lead the discussion, the individual may want their supports coordinator to facilitate the meeting, or the individual may want to select an independent facilitator to lead the discussion), and
- who will record in writing what happens at the meeting.

Topics for a Person-Centered Planning Meeting

These will vary, depending on the individual, but could include:

- What are the individual's dreams and goals for the future, or how do they want to live his or her life?
- What does the individual want more or less of in his or her life?
- Who does the individual want to spend time with?
- What new things would the individual like to do or learn?
- What are some great things others should know about the individual?
- What help and assistance does the individual need?
- What things could get in the way of the individual's dreams and goals?
- What does the individual like to do in his or her free time?
- What supports and services does the individual need to achieve his or her dreams and goals?
- What activities is the individual interested in? (job, hobbies, recreational activities, or volunteer opportunities)
- What health and welfare needs does the individual have?

Step #3 – The Person-Centered Planning Process

The planning process is not a single meeting. It is more likely a series of meetings and may involve additional informal discussions. It is a process. The individual may have a meeting every year, or more often, if needed and desired. While an annual plan review may be a system requirement and involve person-centered planning, the person-centered planning process is not simply an annual plan review. The individual may call a person-centered planning meeting every time his or her wants and needs change.

A person-centered planning meeting may begin with all of the participants introducing themselves and sharing why they are participating in the meeting.

The meeting may start with what is currently working and not working for the individual, or the individual may start by sharing his or her hopes, dreams, and desires for the future. Everyone gets to know the individual better and helps the individual with developing his or her plan to the extent help is asked for by the individual. The individual talks about what may get in the way of achieving his or her goals. It may be a physical or health issue or a skill that the individual wants or needs to learn, or a type of assistance or support that the individual needs. Health and welfare issues are also discussed.

After all of the issues are discussed, the individual and their allies work together to determine what supports and services the individual needs to achieve their dreams, goals, and who can help the individual do so. These include the paid supports in the individual's service plan, and the unpaid supports such as the help the individual's friends, family members, and other allies provide the individual. The plan may be completed in a single meeting or it may evolve over several sessions.

If the individual is unhappy with his or her service plan, the individual must let their supports coordinator know. The individual has the right to reconvene the person-centered planning process or to appeal through the Michigan Department of Community Health Fair Hearing Process. The waiver agent also has a dispute resolutions process.

VII. Organizational Components for Implementing Person-Centered Planning

Shifting from traditional service delivery methods to developing and implementing service plans through the person-centered planning process requires a change in the organization's orientation. Instead of fitting individuals into existing programs, available supports and services must be adapted to meet the needs and desires of the individuals. The following characteristics are essential for organizations responsible for providing supports and services through the person-centered planning process.

A. Person First Language

Person first language puts the person before the medical, physical, or mental condition and maintains the emphasis on the humanity and dignity of the individual. For example, instead of *arthritic person*, the appropriate term would *person with arthritis*. Using person first language is an important first step in reorienting the organization toward the individuals and their needs and desires. Instead of viewing individuals through the narrow scope of their condition or disability, the needs of the whole individual, as well as his or her support system, are identified and addressed.

B. Person-Centered Orientation

The focus must continually be on the individual for whom the plan is being developed and not on plugging that person into available slots in programs. Waiver agents have the responsibility to avoid unintended and detrimental consequences of their involvement, such as individuals becoming disempowered by deferring to professional decision-making, or families becoming displaced by service providers. The general strategy for avoiding these consequences is to presume competence and capacity by the individual, allies and the community, and to only provide assistance when the current situation leaves unmet needs. Just as the language for individuals receiving services has changed, the term supports coordinator has replaced terms such as care manager or case manager to identify the change in role from one who is managing or directing care to one who is supporting an individual to self direct their supports and services.

C. Training, Mentoring, and Support for Staff

The staff should have training and supervision to ensure that they have the knowledge and capacity to meet their person-centered planning responsibilities. These responsibilities may include: providing information and guidance to individuals receiving or seeking supports and services, facilitating the planning meetings as requested by the individual, suggesting creative strategies to address the needs and desires of the individual, and monitoring the effectiveness of the person-centered planning process and service implementation. Training in the tools and methods of person-centered planning process is critical in giving supports coordinators the background to support a variety of individuals and provide a unique response to each individual. Peer mentoring and support may be helpful to develop supports

coordinators capacity in this area. In addition, supports coordinator positions should be designed to accommodate this new role. For example, caseload size must allow for sufficient personal contact, authority to make decisions in support of the individual's choices, flexible hours, and minimal competing duties. Staff performance reviews should include consideration of how well the staff person contributes to person-centered planning, supports individual choices, and helps realize individual goals. Staff performance evaluation should include person-centered planning performance.

D. Community Resource Development

Information on community resources must be available to all staff and individuals. Waiver agents must map community resources and options for community involvement and participation in which individuals express interest must be investigated. The waiver agent must work with other community and government organizations to resolve barriers and advance common aims. This collaborative may include developing resources to meet unmet needs and developing collaborative agreements to resolve barriers and ensure effective resource utilization.

E. Information and Guidance

Each waiver agent must have an organizational commitment to provide information and/or experiences that sufficiently inform an individual of her or his options. Upon initial screening and eligibility determination, supports coordinators must provide individuals and their allies with written information about the right to the person-centered planning process. Supports coordinators may also ensure that individuals have tools to successfully use the person-centered planning process, develop individual quality service expectations that address preferences and evaluation of personal outcomes and goals, and implement arrangements that meet their needs. The supports coordinator must offer additional information and support to the individual and directly address concerns that the individual may have either over the phone or in a face-to-face meeting. Continued assistance is available throughout the planning process, which continues and evolves as each individual receives waiver services. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g. Braille, sign language, audio-recorded documents), hands-on experiences with options and peer support from individuals who have experience using the same supports and services.

Individuals and their allies are provided with telephone numbers to contact supports coordinators when new needs emerge that require the assistance of the supports coordinator or the reconvening of the person-centered planning process.

F. Evaluation and Quality Management

The effectiveness of both the person-centered planning process and the outcomes of that process must be evaluated. The approach to evaluation and quality management must collect and use data, including feedback from individuals on their views of the success of the person-centered planning process and how the process impacts both the service plan development and service plan utilization. Data must be sought through multiple methods such as mail, phone, in-person surveys, focus groups, and other feedback loops.

Measures on the effectiveness and success of the person-centered planning process include whether the individual invites allies important to them to participate in the process, the individual decides who will run person-centered planning meetings, the individual chooses meeting topics and the time and location of the meeting, and the individual's wants and needs are included in the service plan. A short written survey to evaluate the planning process must be provided to the participant with the authorized service plan. Follow-up must be offered to assist the individual in completing the survey in the way that works best for him or her within 30 days of completion of the planning process.

Evaluation of the outcomes of the person-centered planning process include how the services and supports in the plan impact on the individual's ability to realize personal choices, maintain or increase individual's quality of life, and assist in achieving his or her dreams and goals. Data should also be collected and analyzed to assess the impact of the person-centered planning process on individual choices—both realized and not realized—barriers to realizing choices and achieving goals, and efforts to resolve barriers and assess participant quality of life. This data should be collected and analyzed using measures which gauge the individual's quality of life, at least annually.

This quality management process and resulting data is used to improve services and make decisions that lead to better lives for individuals. The goal is to develop a sense of the success of person-centered planning from the individual's viewpoint. Individual preferences are identified through the person-centered planning process and the

evaluation and quality management process needs to reflect the success of supports and services to both include and address these preferences. This management information should be considered in organizational planning, including allocating resources.

After person-centered planning has been implemented over a period of time, the service plans and individual budgets when reviewed across the system can provide useful information about what supports and services are being used by individuals and how resources are being allocated. Such an evaluation is valuable source for information on individual preferences that can provide guidance on how financial and other resources may be allocated in the future and what community capacity and relationships need to be developed.

VIII. Glossary

Allies – Friends, family members and others that the individual chooses to assist him or her in the Person-centered planning process. Allies participate because of their commitment to supporting the individual, not because participation is one of their job duties. The individual determines who is an ally. Allies *may* include family members, friends, or advocates. Allies are not paid professionals (even though professionals may be very committed to supporting the individual).

Arrangements that Support Self-Determination – Methods for an individual to accomplish self-determination in his or her life.

Independent Facilitator – A person the individual chooses to guide and support him or her through the Person-centered planning process.

Independent Living – The term used for both the philosophy and the movement that all people with disabilities, including people with significant disabilities, can maintain a life in the community—with work or other activities, a home, and personal relationships—if they have the right supports and services.

Service Plan – A plan of supports and services for an individual that will be authorized and paid by the waiver agent.

Medicaid – A government program that provides funding for supports and services authorized by the waiver agent.

Person-Centered Planning – A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Self-Determination – The belief and value that individuals who need supports and services have the freedom to define their lives make meaningful choices regarding their lives and have the opportunity to direct the supports and services they need to pursue their lives.

Waiver Agent – The agency that authorizes the individual's service plan.

Supports Coordinator – A person who works for the waiver agent and works with an individual to develop and authorize a service plan. The supports coordinator also provides other assistance and support to the individuals they serve.

From (name): _____ Affiliation: _____

E-mail: _____ Telephone: _____

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES

Subject: Person-Centered Planning for Community Based Long-Term Care: Practice Guidelines

Comments due: July 9, 2007

E-mail to: Gloria Lanum at Lanumg@michigan.gov Fax to: (517) 241 – 2345

Mail to: Michigan Department of Community Health, Office of Long-Term Care Supports and Services, Washington Square Building, 7th Floor, 109 W. Michigan Avenue, Lansing, Michigan 48913

Questions: For questions regarding the Practice Guidelines contact Rob Curtner at (517) 335 – 8710 or e-mail at CurtnerR@michigan.gov

The practice guidelines document is divided into seven (7) sections. Please provide feedback on each section and detail any specific or useful information that you feel should be included and/or what could or should be deleted. Feel free to use additional sheets as needed.

I. Purpose:	
II. Definition:	
III. Background:	
IV. Implementation:	
V. Practical Considerations:	
VI. Process Steps:	
VII. Organizational Readiness:	
Other Comments:	

Person-Centered Planning in Community Based Long-Term Care

Implementation Pathway Elements

Presentation Objectives:

- Place Person-Centered Planning for LTC into a context.
- Identify organizational features to support PCP in LTC implementation.
- Determine an implementation pathway for successful PCP start-up and functioning.

What is Self-Determination?

- Part of a growing National Movement
- It's about Control over their own life
- 5 Features of these initiatives
  - Person-Centered Practices
  - Individual Budgets
  - Use of Fiscal Intermediary Services
  - Quality Assurance
  - Back-Up Plans
- Values and Principles

Self-Determination Values & Principles

CLICK

PCP Basics

The Person-Centered Planning Process:

- Empowers individuals to increase their quality of life.
- The process enables individuals to both address health and welfare issues.

PCP Basics

- How about asking how participants want their services and supports provided?
- How about coordinating with the support of their friends, family members, other allies and chosen professionals?
- The person-centered planning process ensures that individuals who need long-term care supports and services have a method for identifying the care that they want and need.

PCP Basics

In the person-centered planning process, individuals—with the support of allies and chosen professionals—

THE PARTICIPANT DECIDES & CONTROLS:

- The support they need and want to address life goals;
- such as where they want to live,
- how they want to connect with others,
- the activities in which they want to participate.

PCP Basics

The individual's choices drive an ongoing process of:

- setting goals,
- making plans,
- selecting supports and services,
- evaluating supports, and
- revising or setting new goals.

PCP Basics

- The goals and identified services and supports are incorporated into a service plan that includes both paid services and supports (such as MI Choice waiver services) and
- Unpaid support (such as care provided by a spouse) that shapes service delivery implementation and is revised as needed.

Providing Supports

Many of the essential elements of the person-centered planning represent common sense:

- Individual decisions should be driven by their life goals and priorities,
- Individuals should know their options,
- Individuals should make their own decisions,
- Individuals should have the support of allies in developing and implementing their services and supports.

Essential elements for the person-centered planning process

- Control over Choice
- Use of Pre-Planning Meeting
- Control over Planning Process and Plan
- Informal Supports & Non-paid Support Providers
- PCP Drives Supports
- Monitoring and Evaluation from participant view
- PCP oriented Documentation

Beyond the Person-Centered Planning Meeting and Plan

- What cultural and organizational features can contribute to the development, growth and integration of Person Centered Thinking?

- Beyond training staff; what else could/should the organization do to develop supports for PCP?

Good paper versus good lives

In a culture in which good paper takes precedence over a good life,

- The mission/vision is about helping people get good lives.

BUT

- Efforts to get good lives are not noticed,

WHILE

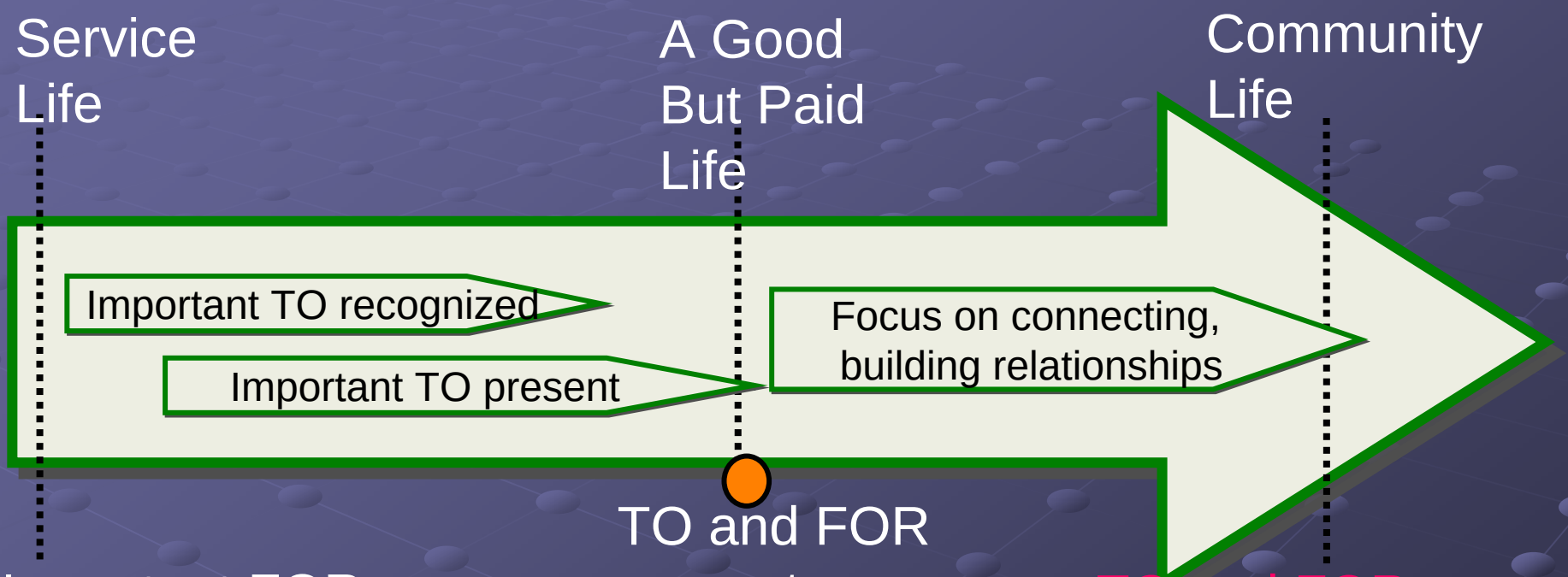
- The behavior of senior managers tells front line managers that good paper is rewarded and bad paper is punished,

AND

- The people who use the services often have good plans but lives where what is really important to them is absent.

Whose definition of what is important?

Important to Whom?



Important FOR addressed

No organized effort about important TO

TO and FOR present

Closest people paid or family

Few real connections

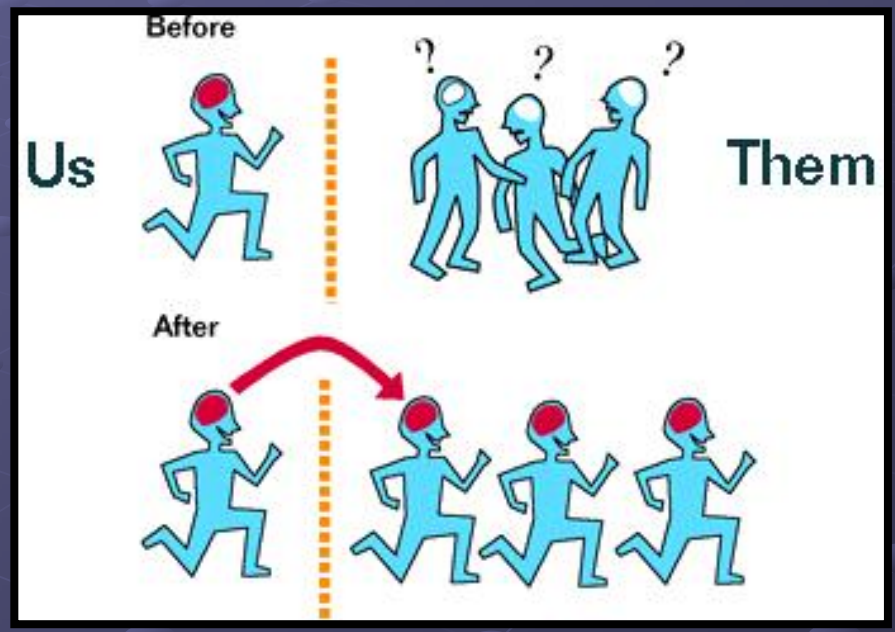
TO and FOR present

Active circle of support

Included in community life

Who is involved?

- Participant/Consumers
- Agency Administration and Board Members
- Staff
- Community



- Alignment is the goal

What actions are useful?

- Training
- Culture Change
- Policy
- Best Practices
- Documentation
- Quality Management Process

Person-Centered Planning
in Community Based Long-Term Care
Implementation Pathway Elements

DRAFT DOCUMENT

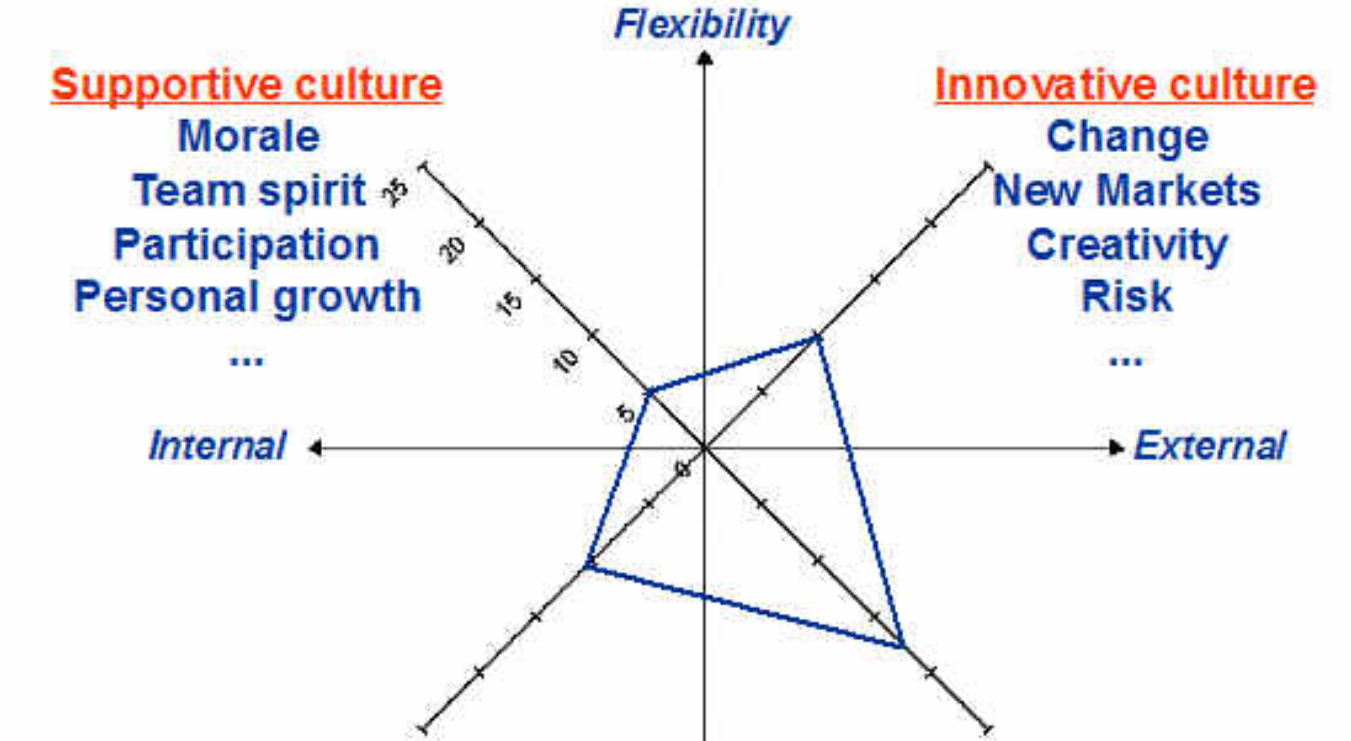
WHO?

	= Training & Communications	= Support for Culture Change	= Policy	= Best Practices & Documentation	= Continuous Quality Improvement
Agency Leadership Adm./ Board	•Model Person-Centered language •Provide flexibility for time to do PCP •Go on-record as supporting PCP	•Identify changes needed at all levels in organization •Lead the change •Provide rewards •Expect & utilize resistance to change	•Policy expectations include Person-Centered Thinking and PCP in all activities.	•Policy base expects & recognizes PCP as basis for assisting participants. •Consumer orientation extends to all levels of care	•Develop meaningful CQI plan & monitor results and progress •Use quality data to make decisions •Measure effectiveness
Staff	•Observe/mentor others •Train all staff in PCP •Develop skills in observed practice •Manage performance expectations	•Ask for and give feedback •Internalize values of PCP •Develop policy and Make policy work	•Write, practice and improve PCP policy with consumer input	•Coaching & super-vision on PCP performance. •Ask key questions to determine needs & wants	•Follow CQI* plan •ID ways to improve PCP •Use quality data to make decisions •Ask good questions
Consumer – Participants	•Provide PCP orientation for supports & services •Families and allies are involved in training	•Participant input to plan & govern provider orgs. •Grievance/appeal process includes use of outside advocates	•Consumer are involved with policy development •Explain to participants the intent, responsibilities and features of PCP	•Assure choice and control over plan •Up-date plan as needed. •Best practices includes PCP approach	•Track & follow-up on participants •Use quality of life measures •Participants are the experts on their own life
Community	•Use Person- Centered language in PR materials •Outreach activities for developing community supports	•Choose and use supports •Set and monitor standards and expectations for PCP values in health care	•Make choice and control features of program part of out-reach materials	•Create community- wide expectations re: PCP •Actively recruit needed supports in community	•Report quality findings •Ask for community input on service quality •Broker needed supports

TASKS →

*CQI = continuous quality improvement

Organizational Culture: Control vs. Flexibility



Managing Key Success Factors

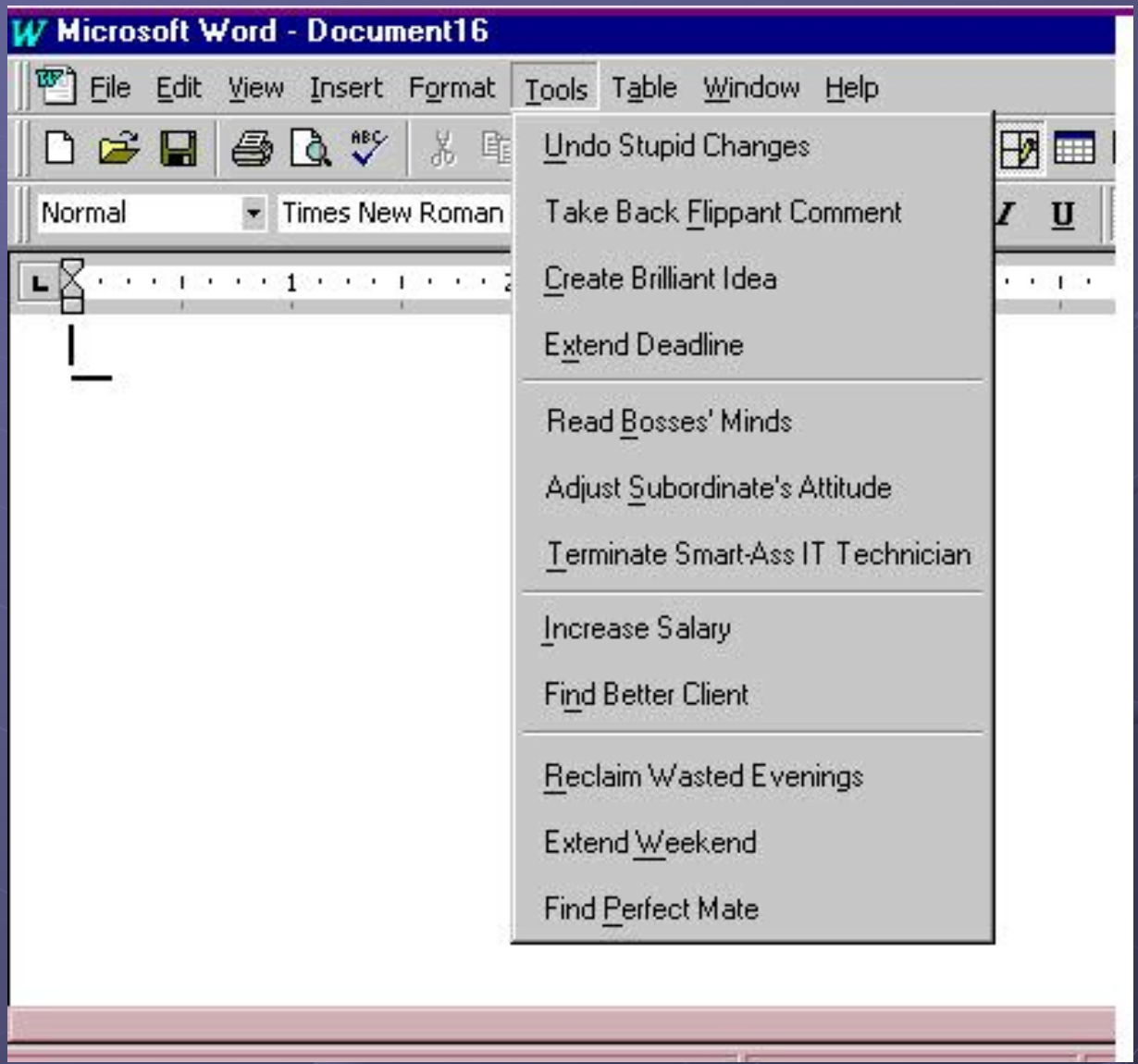
Leadership	+	Knowledge	+	Focused Actions	+	Resources	+	Measures	=	**Change**
		Knowledge	+	Focused Actions	+	Resources	+	Measures	=	**Confusion**
Leadership	+			Focused Actions	+	Resources	+	Measures	=	**Anxiety**
Leadership	+	Knowledge	+			Resources	+	Measures	=	**False Starts**
Leadership	+	Knowledge	+	Focused Actions	+			Measures	=	**Frustration**
Leadership	+	Knowledge	+	Focused Actions	+	Resources			=	**Gradual Change**

Leave out parts of the process and get mixed results…

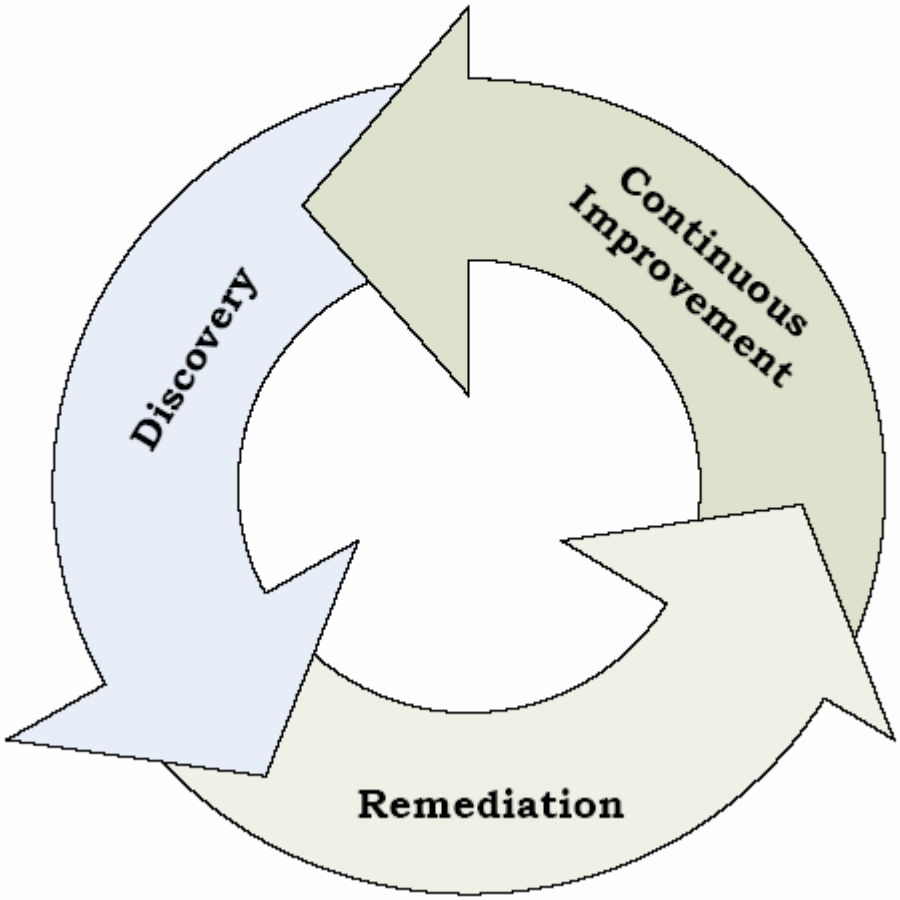
Confusing Signals

- Thinking about what is needed across areas of organizational functioning avoids mixed messages about the intent and expectations for how PCP is implemented and practiced.
- By focusing on the big picture, the little pictures go together.

Taking Meaningful Action



Quality Management Process



Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Reliable and robust system of discovery methods

- Protocols for data collection
- Qualified reviewers/interviewers
- Sampling methods that allow conclusions
- Standard data collection instruments
- Reliable and accurate data
- Ability to transform data into useful and actionable information

PCP Implementation

Who/ Does What?	Training	Culture Change	Policy	Clinical Best Practices	Documentation	Continuous Quality Improvement (CQI)
Participant/ Consumers						
Agency Adminis-tration & Board Members						
Staff						
Community						

PCP Implementation

Who/ Does What?	Training	Culture Change	Policy	Clinical Best Practices	Documentation	Continuous Quality Improvement (CQI)
Participant/ Consumers	X	X	X	X	X	X

PCP Implementation

Who/ Does What?	Training	Culture Change	Policy	Clinical Best Practices	Documentation	Continuous Quality Improvement (CQI)
Agency Leadership Adm./ Board	X	X	X	X	X	X

- **All staff and board members receive training on PCP**
- **Implementation progress is monitored and enhanced**
- **All are involved in policy development**
- **Success with PCP implementation is shared/celebrated with board**
- **Board is involved with Quality Management review/decisions**

PCP Implementation

Who/ Does What?	Training	Culture Change	Policy	Clinical Best Practices	Documentation	Continuous Quality Improvement (CQI)
STAFF	X	X	X	X	X	X

- **Staff take responsibility for training informally to assure that person-centered language and PCP process us used.**
- **Hiring practices reflect preferences for person-centered approach.**

PCP Implementation

Who/ Does What?	Training	Culture Change	Policy	Clinical Best Practices	Documentation	Continuous Quality Improvement (CQI)
Community	X	X	X	X	X	X

- **PCP orientation/training for partner agencies & community groups**
- **Encourage community partners to use person first language**
- **Organization's policy supports**

Information and Assistance Caller Interview Protocol
DRAFT 5.31

This document describes procedures for completing I&A Caller Interviews. The purpose of this protocol is to ensure that interviews are conducted in the same way across and within LTCC sites. Please follow these procedures closely when conducting I&A Caller Interviews. Individuals responsible for carrying out these activities will receive training. If you have any questions or need clarification, please do not hesitate to contact Julia Heany at 517-324-7349 or jheany@mphi.org.

Interview Purpose

The I&A Caller Interview is designed to measure the extent to which the LTCC sites have met the following objectives:

- Consumers and providers felt they came to the right place for information and assistance. (ADRC)
- Consumers feel they are served in a timely manner. (ADRC)
- Consumers, families, and providers receive clear, culturally competent, useful, timely, unbiased, and reliable information from MILTCC. (ADRC & STG)
- Primary and secondary consumers used the information they received. (ADRC)
- Customer satisfaction with the objectivity, reliability, comprehensiveness, currency, & usefulness of information, focusing on responsiveness to needs, preferences & unique circumstances; information being simple & clear; and interaction with ADRC staff. (ADRC)
- The proportion of people who access the one-stop system who report that they were satisfied with the access services received, including satisfied with culturally and linguistically competent services (including alternative formats) and satisfied overall (STG)
- Consumer satisfaction with services provided. (PA634)
- Timeliness of delivery of services provided. (PA 634)

In addition the interview will be used for quality management purposes.

Participant Selection Procedures

The population from which participants will be selected includes all callers who[1]:

1. Left a phone number;
2. Gave the LTCC permission to call them back; and
3. Are not in options counseling.

10% of this population will be surveyed per year, and surveys will be conducted on a weekly basis. The number of surveys each site will be required to complete each week will be calculated based on the number of callers that meet the above criteria who

[1] The selection criteria will need to address the issue of repeat callers. The evaluation team will consider this issue further.

were served in the previous month. The number of surveys required per month will shift slightly from month to month to adjust to current call volume.

> For example, if your site served 400 callers in June who left a phone number, gave permission to cal them back, and are not in options counseling, than your site will be required to complete 40 surveys in July, or approximately 10 surveys per week.

Survey participants will be selected at random on a weekly basis. Each site will generate a report from Service Point of the callers that met the above criteria who were served during the previous week. This list will sort callers by those who were calling for themselves, those who were calling for someone else, and those who were calling in a professional capacity. The number of individuals selected from each of these groups should reflect the proportion of calls that fell into these categories. This strategy will help us ensure that consumers are not under-represented in our sample.

> For example, if you need to complete 10 surveys this week and 30% of your callers called for themselves, 40% called for someone else, and 30% were professionals, you would randomly select 3 people who called for themselves, 4 people who called for someone else, and 3 professionals.

Participants will be selected at random using a table of random numbers. A list of all the callers who meet the above criteria will be generated, including each participant's Service Point assigned ID number. Beginning at a random spot on the table, each participant with an ID number that matches a number displayed on the table of random numbers will be chosen to participate in the study until the quota for each group (called for self, called for someone else, professional) is filled. If a participant chooses not to respond to the questionnaire, or can not be contacted, a replacement participant will be selected at random. Interviews must be ***completed*** with 10% of callers.

Interview Procedures

Each site will identify an appropriate individual or individuals to conduct interviews. Interviewers may not conduct interviews with callers who they served. All interviewers will be trained by the evaluation team.

Interviews will be conducted on a weekly basis with callers who were served by the LTCC during the previous week. This will facilitate recall while allowing the caller time to receive and process any information they requested.

Interviewers will make a significant effort to contact each caller selected to participate in the interview. Interviewers will attempt to call each caller three times, leaving messages each time, if possible. Interviewers will call at different times of day and use alternative numbers, if available. If a caller can not be reached within three days, an alternate caller will be selected at random. Callers who are difficult to reach may be different in important ways from callers who are easy to reach. Therefore it is critical that every attempt be made to contact each caller selected for the interview.

Before each call, the interviewer will write the caller's ID number and the LTCC site name on each page of the survey in the upper right-hand corner and fill out the demographic information on the last page of the survey using the caller's Service Point record. The interviewer will also review the caller's Service Point record in order to gather some background information regarding why the caller contacted the LTCC. This information may be helpful if the caller can not remember why they called or what services were provided.

After reaching the caller, the interviewer will follow the interview script. After introducing themselves and the interview, the interviewer will give the caller the opportunity to either complete the survey now, schedule a time to complete the survey later, or to decline to participate. If the caller does not remember contacting LTCC the interviewer will attempt to jog his or her memory based on information in the caller's Service Point record. However, if the caller can not remember calling, the interviewer will end the call and check the appropriate line on the first page of the interview protocol.

When the interview begins, the interviewer will follow the interview script. The interviewer will read instructions and each item slowly and clearly. The interviewer will answer any questions that arise and make note of any issues that may need to be discussed with the evaluation team. If the interviewer is unsure how to answer a caller's question about an item, the interviewer should say, "That is a good question. Please interpret the item in a way that makes sense to you." Any comments that the caller makes over the course of the interview should be written down, using the caller's language as much as possible. The interviewer should give the caller time to discuss any issues that arise and provide any LTC related I&A that the caller requests at the end of the interview. It is important to delay discussing additional questions or requests for service until the interview is completed. For example, the interviewer might say, "Your request is very important to me. After the interview is completed I can devote my whole attention to it."

The last page of the interview script includes information that may be in the caller's Service Point record. Any information the LTCC has already collected does not need to be verified during the interview. Any missing information should be collected at the end of the interview.

At the end of the interview, the interviewer should thank the caller for his or her time, provide the name and number of a member of the evaluation team, and provide the number of the LTCC. The interviewer should also ask whether there is anything else he or she can do to help the caller.

After the interview, the interviewer should review the interview script, filling in or clarifying any comments and making sure all responses are clearly marked.

Data Submission Procedures

At the end of each month, each site will mail copies of their interviews to Julia Heany at 2440 Woodlake Circle, Suite 100, Okemos, MI 48864. Any identifying information should

be blacked out on the copy sent to the evaluator. The evaluation team will edit, enter, and analyze results for each site and for the state on a quarterly basis for the duration of the evaluation. Sites will be provided with raw data tables and they will keep original copies of the interviews for their records. The evaluator will provide each site with an Excel file and protocol for editing, entering, and analyzing its own data at the end of the evaluation period.

_____ _____
MILTCC *Caller ID*

Information and Assistance Caller Interview
DRAFT 5.30

Before calling, fill in Caller ID and your site name in the top right corner of each page, as well as the demographic information on the last page.

Introductory Script:

Hello. May I speak with [caller's name - *do not record on this page*].

Hello, [name]. My name is [interviewer name]. Recently you contacted [site name], and I am calling today from [site name] to ask a few questions about how satisfied you were with our services. We are always trying to do a better job helping people with long term care needs, and feedback from people who use our services helps us figure out how we can improve.

If you decide to talk with me today, your comments will be completely confidential. We will never identify you or your comments. We combine all the responses we receive and talk about all the responses, not your alone. Also, what you say will not affect the services you receive in the future.

We are very interested in your honest opinions. The questions I have will take about 10 minutes to answer. I have questions about both the information you received from [site name] and the quality of the services provided by [site name]. Are you willing to talk with me today, or can we schedule a time in the next couple days to talk?

[Check one]

___ *Will participate today*
___ *Will participate on: _____ (date) at _____ (time)*
___ *Declined to participate*
___ *Does not recall contacting MILTCC*

_____ _____
MILTCC *Caller ID*

Interview

Thank you for agreeing to talk with me today. Do you have any questions before we begin?

Let's begin with some questions about the information you received when you contacted [site name]. I am going to read several statements. I'd like you to tell me whether you strongly disagree, disagree, agree, or strongly agree with each statement. Does that make sense?

*[Read each statement and all four response options. Do not read "don't know" or "NA" but use as appropriate. Skip items that are preceded with a * if talking with a professional and circle "NA."]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	NA
1. I received the information I wanted.	1	2	3	4	98	99
2. The information I received was clear.	1	2	3	4	98	99
3. The information I received was accurate.	1	2	3	4	98	99
4. The information I received was helpful.	1	2	3	4	98	99
5. *The information I received gave me choices.	1	2	3	4	98	99
6. *The information I received respected my beliefs.	1	2	3	4	98	99
7. *The information I received respected my preferences.	1	2	3	4	98	99
8. I understood the information I received.	1	2	3	4	98	99
9. I used the information I received to make decisions.	1	2	3	4	98	99

10. Do you have any comments about the information you received that you would like to share with me before we go to the next section?

_____ _____
MILTCC *Caller ID*

Now I would like to talk with you about the quality of the services you received from [insert site name]. Again, I am going to read several statements. I'd like you to tell me whether you strongly disagree, disagree, agree, or strongly agree with each statement. Do you have any questions?

*[Read each statement and all four response options. Do not read "don't know" or "NA" but use as appropriate. Skip the item that is preceded with a * if talking with a professional and circle "NA."]*

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	NA
11. The person I spoke with seemed to know what he/she was talking about.	1	2	3	4	98	99
12. The person I spoke with was courteous.	1	2	3	4	98	99
13. *The person I spoke with was respectful of my beliefs.	1	2	3	4	98	99
14. The person I spoke with listened carefully to what I wanted.	1	2	3	4	98	99
15. I was able to talk to someone in a reasonable amount of time.	1	2	3	4	98	99
16. I got information in a reasonable amount of time.	1	2	3	4	98	99
17. I was very satisfied with the assistance I received.	1	2	3	4	98	99
18. I would use this service again in the future, if needed.	1	2	3	4	98	99
19. I would recommend this service to someone else who needed it.	1	2	3	4	98	99

20. Do you have any comments about the quality of the services you received?

21. Is there anything I can help you with today, or do you have any other comments you'd like to share with me?

_____ _____
MILTCC *Caller ID*

Please fill in this section prior to completing the call based on the caller's Service Point record. If any fields are missing, please ask the consumer for the missing information at the end of the call. Only ask the caller for information that is missing.

Before we hang up, I would like a little information about you. This information will tell us a little about the people we are reaching with our services, but you do not have to answer any questions you'd rather not answer.

22. When you called or visited our office, for whom were you seeking help?
    - ☐ Self (answer q. 23-24)
    - ☐ Parent
    - ☐ Child
    - ☐ Other relative
    - ☐ Friend
    - ☐ Client (answer q. 25-26)
    - ☐ Professional (not for a client - end survey)

23. *Are you 60 years of age or older?
    ☐ No ☐ Yes ☐ DK

24. *Do you have a disability?
    ☐ No ☐ Yes ☐ DK

25. *Did you call for someone 60 years of age or older?
    ☐ No ☐ Yes ☐ DK

26. *Does the person you called for have a disability?
    ☐ No ☐ Yes ☐ DK

[If called for "self" or "parent, child, other relative, friend, or client," continue with q. 27]

27. *What is your race/ethnicity [please check all that apply]?
    - ☐ American Indian or Alaska Native
    - ☐ Native Hawaiian or Pacific Islander
    - ☐ Asian
    - ☐ Black or African American
    - ☐ Hispanic/Latino
    - ☐ White or Caucasian
    - ☐ Other, please specify _____

28. *What is your gender?
    ☐ Male ☐ Female ☐ DK

29. *What is your income?
    - ☐ Poverty level or less
    - ☐ Above poverty level but 300% of poverty or lower
    - ☐ Above 300% of poverty level
    - ☐ DK

30. *What county do you live in?

    _____

Thank you very much for talking with me today. If you have any questions about this interview, please contact Julia Heany at 517-324-7349. If you have questions or need assistance with long term care, please contact [insert correct #].

Overview

Centers for Medicare and Medicaid Services
Real Choice Systems Change
Grant Opportunities

Purpose

The general purpose of the Real Choice grants is to advance the New Freedom Initiative priorities, which include system changes that support living in the most integrated setting, consumer choice and quality services. This solicitation includes two grant opportunities:

1. State Profile Tool: Assessing a State's Long-Term Care System

CMS is developing a tool for assessing and tracking a state's efforts to rebalance its long-term care system. These grants allow states to adapt the profile model developed with Pennsylvania. The profile is a combination of descriptive and quantitative data that can be used to:

- Provide policymakers and stakeholders with a shared high-level view of the system
- Identify opportunities for system improvements and service gaps
- Acknowledge success
- Provide a framework for comparing rebalancing efforts across states

2. Person-Centered Planning Implementation Grant.

The goal is to develop and implement a PCP model, which consists of an informal support assessment and intervention process, including a community network assessment and implementation process designed to enduring relationships and

community ties. States may also develop any of the following optional components: self-direction, web-based resource directory, risk management strategy, web-based care planning tool, evidence-based practices or planning for youth with co-occurring disorders.

Timeline

- Voluntary notice of intent to apply: June 29, 2007
- Grant applications due: July 27, 2007
- Grant period: September 30, 2007-September 29, 2010

Funds available

- Total available: $13 million
- Grant awards will be for $350,000 to $500,000 over a 3-year period.
- Estimated number of awards: State profile tool, 10-15; Person-centered planning implementation, 8-10, states may apply for more than one grant

Further information

The full solicitation can be found at the Real Choice webpage. Scroll to the first download document.
http://www.cms.hhs.gov/RealChoice/

Invitation from Norm Delisle, Michigan Disability Rights Coalition, to receive news about long-term care developments:

Want to keep up on national and state developments in LTC reform without the hassle of looking? Check out http://ltcreform.blogspot.com/ a LTC blog with a Michigan focus. If you like the news on the blog, you can subscribe to a summary newsletter that comes out only once a week, with links to the new articles on the blog. Subscribe by putting your email address in the subscribe box at the top of the blog and press the button.

Save the Date!

10th Annual Person-Centered Planning Conference

Somerset Inn
Troy, Michigan

Wednesday and Thursday
September 19 & 20, 2007

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